No. 09-364

Supreme Court, U.S.
FILED
DEC 15 2009
OFFICE OF THE CLERK

In The

Supreme Court of the United States

DR. DRALVES GENE EDWARDS,

Petitioner,

v.

BLUE CROSS BLUE SHIELD OF TEXAS,
A DIVISION OF HEALTH CARE SERVICE CORP.,

Respondent.

On Petition For Writ Of Certiorari
To The Texas Court Of Appeals
For The Fifth District

REPLY BRIEF

DR. DRALVES GENE EDWARDS
Pro Se
1532 Chapman Street
Cedar Hill, TX 75104
214-215-4425

TABLE OF CONTENTS

	Page
INTRODUCTION	1
I. A Split Among the Lower Court Exists on Whether State Law Remedies Are Preempted under the Medicare Act	4
II. State Law Remedies Are Needed to Redress Fraudulent and Tortious Conduct by Fiscal Intermediaries	5
III. The Administrative Review Process Is Not the Sole Remedy for Fraudulent and Tortious Conduct by Fiscal Intermediaries	9
CONCLUSION	12

TABLE OF AUTHORITIES

Page

CASES

Ackerman v. United Healthcare Serv., Inc., 2009 WL 1769393 (S.D. Miss. 2009) 7

Albright v. Kaiser Permanente Med. Group, 1999 WL 605828 (N.D. Cal. 1999).....6

Altria v. Good, 129 S. Ct. 538 (2008) 6

Ardary v. Aetna Health Plans of Southern California, 98 F.3d 496 (9th Cir. 1996) 5, 11

Bodimetric Health Servs. v. Aetna Life & Cas., 903 F.2d 480 (7th Cir. 1990) 4

City of Worchester v. HCA Mgm't Co., 753 F.Supp. 31 (D. Mass. 1990).....11

Fisher v. United States, 529 U.S. 667 (2000).....6

Group Health Inc. v. Blue Cross Assoc., 625 F.Supp. 69 (S.D.N.Y. 1985) 11

Harris v. Pacificare Life & Health Ins. Co., 514 F.Supp.2d 1280 (M.D. Ala. 2008).....7

Heckler v. Ringer, 466 U.S. 602 (1984) 9, 11, 12

Hofler v. Aetna US Healthcare of Cal., Inc., 296 F.3d 764 (9th Cir. 2002) 11

Jamaica Hosp. Nursing Home v. Oxford Health Plans, 2000 U.S. Dist. LEXIS 13917 (S.D. N.Y. 2000).....11

Kaiser v. Blue Cross of Cal., 347 F.3d 1107 (9th Cir. 2003).....4

TABLE OF AUTHORITIES – Continued

Page

Kelly v. Advantage Health, Inc., 1999 WL 294796 (E.D. La. May 11, 1999) 4, 7, 10, 11

Kennedy v. Health Options, Inc., 329 F.Supp.2d 1314 (S.D. Fla. 2004) 6

Livingston v. Blue Cross of Ala., 788 F.Supp. 545 (S.D. Ala. 1992) 11

McCall v. PacifiCare of Cal., 21 P.3d 1189 (Cal. 2001) 6

Salas v. Grancare, No. 09CA0089 (Colo. App. 1/04/2001) 4

Wartenburg v. Aetna U.S. Healthcare, Inc., 2 F.Supp.2d 273, 280 (E.D.N.Y. 1998) 8

Williams v. Viva Health, Inc., 2008 WL 220799 (M.D. Ala. 2008) 7

Wyeth v. Levine, 129 S. Ct. 1187 (2009) 6

Zolezzi v. PacifiCare of Cal., 129 Cal. Rptr. 2d 526 (Cal. App. 2003) 6

STATUTES

42 U.S.C. § 1395c 7

42 U.S.C. § 1395j 7

43 U.S.C. § 405(g) 11

RULE

S.Ct. Rule 10 5

This case is not about petitioner attempting another run at remedies for respondent's erroneous denial of Medicare claims payments. Rather, this case is about why those denials began in the first place. The distinction between the erroneous denial of Medicare claim payments (which petitioner has already succeeded in proving to an administrative judge) and the erroneous placement of petitioner on 100% prepayment review (which functioned as 100% denial of Medicare payments) is, for purposes of federal preemption, the difference between apples and steak. While a reasonable mind could differentiate between the two, only this respondent would say they are in the same class.

INTRODUCTION

Dr. Dralves Gene Edwards is a board certified family physician in Texas who made house calls on the elderly as well as treated patients in his office. Around 90% of his patients were enrolled in the Medicare program, and he was one of the highest billing doctors to Medicare in the Dallas area.

Respondent, a Medicare fiscal intermediary, placed petitioner on 100% prepayment review without justification and later, denied 100% of petitioner's Medicare claims. In doing so, respondent contravened a number of Medicare guidelines. Respondent conducted a 100% prepayment review without identifying a problem.

The 100% review, combined with the sluggish administrative review process, cost petitioner his medical practice and resulted in many of Dallas' elderly and needy to go without medical care. This was, petitioner believed, the desired result; because respondent needed to cut costs in order to resign a government contract and continue to perform as a Medicare fiscal intermediary. Moreover, the respondent needed to cut costs in order so they could get their government contract renewed as a Medicare fiscal intermediary.

Petitioner ultimately prevailed on 98% of his Medicare claims in the administrative review process, but by then irreparable harm had been done and his medical practice had to close.

To this day, respondent has not provided any answer as to why petitioner was placed on 100% review or an explanation of how a valid prepayment review could result in the closure of a medical practice. Medicare audits and reviews are designed to make sure benefits are paid for services that are covered under Medicare and are reasonable and medically necessary. The review helps to provide uniform national standards for the payment of benefits.

Petitioner brought suit for state law breach of contract, fraud and tort claims and sought consequential damages from the illegal placement on the 100% review and denial list. At issue in the suit, was not the denial of claims themselves, which were

already decided in petitioner's favor by administrative review. The "real issue," was why respondent – contrary to established Medicare guidelines – placed petitioner on the 100% review in the first place. Respondent's Brief In Opposition, at 3 ("Resp.___").

While respondent admits that Blue Cross' decision to place all of petitioner's claims on prepayment review is the "real issue," respondent attempts to dilute the question of whether petitioner's state law claims are preempted by the Medicare Act by parading the fact that petitioner finished the administrative review process. Resp. 3. This fact only aids petitioner's claim against preemption rather than hinders it.

Respondent also brings a long-waived state statute of limitations claim, even though this Court's normal practice is to decide only federal claims properly raised and decided by the courts below. The statute of limitations issue, raised too late in the day, falls through the strainer of this practice.[1]

In the end, respondent cannot counter the fact that the federal preemption question presented has divided the lower courts. Moreover, the question impacts the day-to-day management of health care management by both physicians and Medicare carriers. For these reasons, the Court should grant review.

---

[1] The statute of limitations argument was not raised in the court of appeal. Nor was it mentioned by the lower court. As such, it is waived.

I. A Split Among the Lower Court Exists on Whether State Law Remedies Are Preempted under the Medicare Act.

There exists a very real split among lower courts over whether state law remedies are preempted by the Medicare Act. Some courts hold that any state law claims implicating the denial of Medicare benefits are inexplicably intertwined with Medicare and thus, preempted. *See e.g.*, *Bodimetric Health Servs. v. Aetna Life & Cas.*, 903 F.2d 480 (7th Cir. 1990) (holding that state law breach of contract, tortious breach of implied covenant and torts inextricably intertwined); *Kaiser v. Blue Cross of Cal.*, 347 F.3d 1107 (9th Cir. 2003) (contractual claims, constitutional claims, and torts preempted by Medicare Act). Other courts have found that state law remedies implicating Medicare are not inextricably intertwined. *See e.g.*, *Ardary v. Aetna Health Plans of S. Cal.*, 98 F.3d 496 (9th Cir. 1996) (state law wrongful death and negligence claims not preempted); *Salas v. Grancare*, No. 09CA0089 (Colo. App. 1/04/2001) (state law fraud and breach of contract claims not inextricably intertwined); *Kelly v. Advantage Health, Inc.*, 1999 WL 294796 (E.D. La. May 11, 1999).

Respondent urges that these cases are distinguishable because one line of cases involves patients and the other providers. Resp. 18. But that rationale has not been uniformly espoused. In fact, the court in this case concluded that petitioner's state law claims would require an appraisal of the denial of Medicare benefits and based upon that reason, the state law

claims were inextricably intertwined. Pet. App. 17. Moreover, such a distinction by the courts of appeals would be remarkable, given that the express language of the Medicare Act itself applies the same administrative and judicial review requirements to "any individual."

What really divides the lower courts is whether state law claims are available at all, even after administrative review. In this case, the court of appeals held that although petitioner exhausted administrative review and succeeded in vindicating his claims, he could seek no further remedies. Pet. App. 17-18. But the court in *Ardary* expressly rejected this reading of Medicare Act preemption. *Ardary*, 98 F.3d at 498 (rejecting the view that private Medicare representatives cannot be held responsible for tortious acts committed in the context of the denial of Medicare benefits).

Thus, it is clear that the lower courts are experiencing difficulties distinguishing what type of state law claims are "inextricably intertwined" with the Medicare Act. Such division is, of course, a paradigmatic factor warranting this Court's review. S.Ct. Rule 10.

II. State Law Remedies Are Needed to Redress Fraudulent and Tortious Conduct by Fiscal Intermediaries.

This Court has continually noted that the federal government's prosecution of fraud is augmented by

the enforcement of state remedies. *See e.g., Altria v. Good*, 129 S. Ct. 538 (2008); *Wyeth v. Levine*, 129 S. Ct. 1187 (2009). In *Altria*, the Court observed that "[t]he [Federal Trade Commission] has long depended on cooperative state regulation to achieve its mission because, although one of the smallest administrative agencies, it is charged with policing an enormous amount of activity." 129 S. Ct. at 544 n.6. Similarly, in *Wyeth*, the Court explained that state law remedies, such as torts, "serve a distinct compensatory function that may motivate injured persons to come forward with information." 129 S. Ct. at 1202. The Court's emphasis that federal Medicare does not preempt all state law remedies is simply a recognition that in most cases, federal and state law work together to benefit the country.

State fraud and tort laws are no exception to this rule. In many instances, the federal Medicare statute provides no remedy for individuals harmed by Medicare fiscal intermediaries. In such cases, state laws provide the only avenue for relief for the wrongful or fraudulent actions by fiscal intermediaries. For this reason, lower courts have allowed individuals harmed by Medicare plans to rely upon state relief. *See e.g., Kennedy v. Health Options, Inc.*, 329 F.Supp.2d 1314 (S.D. Fla. 2004) (premature release from hospital); *Zolezzi v. PacifiCare of Cal.*, 129 Cal. Rptr. 2d 526 (Cal. App. 2003) (refusal to authorize surgery); *McCall v. PacifiCare of Cal.*, 21 P.3d 1189 (Cal. 2001) (refusal to provide referral to specialist); *Albright v. Kaiser Permanente Med. Group*, 1999 WL 605828 (N.D. Cal. 1999) (refusal to honor referral provided by

plan physician); *Kelly v. Advantage Health, Inc.*, 1999 WL 294796 (E.D. La. 1999) (denial of doctor's request for inpatient hospital admission). State law claims have also been utilized when a managed care plan fraudulently enrolls a beneficiary without his consent. *Ackerman v. United Healthcare Serv., Inc.*, 2009 WL 1769393 (S.D. Miss. 2009). *See also Harris v. Pacificare Life & Health Ins. Co.*, 514 F.Supp.2d 1280 (M.D. Ala. 2008) (misrepresentation that required to enroll in managed care); *Williams v. Viva Health, Inc.*, 2008 WL 220799 (M.D. Ala. 2008) (failure to disenroll).

As Justice Kennedy explained in a case involving federal prosecution for Medicare fraud: "The structure and operation of the Medicare program reveal a comprehensive federal assistance enterprise aimed at ensuring the availability of quality health care for the broader community." *Fisher v. United States*, 529 U.S. 667, 680 (2000); *see also* 42 U.S.C. § 1395c; 42 U.S.C. § 1395j. The availability of quality health care for everyone can only be enhanced by enforcement of state law prohibiting fraud and torts.

This case presents a prime example of how state law can ensure "the availability of quality health care for the broader community." *Fisher, supra*. Here, one of the largest billers to Medicare in the Dallas area and one of the few physicians who made house calls to the elderly was placed on the 100% prepayment review without justification.

A clear example is in Texas, there are 254 counties, of which, 27 have no doctor at all. A large

physician recruitment firm reported in 2005, unfortunately, for the first time, open positions for primary care physicians exceeded searches over specialists. Similarly, medical school graduates choosing family medicine dropped from 2340 in 1997 to 1132 in 2006. The respondent targeted petitioner to improve their profits and retain the Medicare contract. Declining access to medical care will always take second place to profits. Therefore, pushing petitioner out of business did not save lives but increased cost. And because petitioner could only recover the cost of the Medicare payments alone, respondent was not punished for its fraudulent and tortious behavior.

In such cases where no state law remedies exist, fiscal intermediaries have no incentive to act appropriately. Nor can fiscal intermediaries be relied upon to act accordingly on their own, for financial factors will always outweigh community needs. State law remedies are thus needed to compliment federal Medicare law and in no way frustrate the overarching aim of the Medicare statute to facilitate quality health care.

In sum, while the federal Medicare statute provides an avenue for appealing a denial of benefits, state law remedies retain an important role in our cooperative federal-state system of insurance under Medicare. As noted in a wrongful death case, "preemption would seriously infringe upon strong state interests in regulating the quality medical care provided to its citizens." *Wartenburg v. Aetna U.S.*

Healthcare, Inc., 2 F.Supp.2d 273, 280 (E.D.N.Y. 1998). Specifically, for negligent and fraudulent actions, state fraud and tort statutes are vitally important to compensate both physicians and beneficiaries for serious financial loss, bodily harm, and even death, and are necessary to deter Medicare fiscal intermediaries from inflicting such harms on others.

Given the important role that state remedies play in forcing fiscal intermediaries to provide quality medical care to citizens, this Court should grant review.

III. The Administrative Review Process Is Not the Sole Remedy for Fraudulent and Tortious Conduct by Fiscal Intermediaries.

Respondent alleges that the administrative review process was the sole remedy that petitioner could seek. Resp. 19-20. But to make that argument respondent must contort petitioner's claim into one alleging "the denial of Medicare claims." Resp. 21. Thus, respondent implicitly recognizes that if petitioner's claim does not challenge the denial of benefits, it is not inextricably intertwined with Medicare and other state law remedies can be pursued.

As one district court held:

> Nothing in *Heckler* compels a reading of the phrase "arising under" to encompass all state-law claims that relate to a denial of benefits. Unlike the plaintiffs in *Heckler*, petitioner's claims do not "at bottom" seek

> reimbursement of Medicare benefits. In fact, plaintiff eventually received all of the requested benefits during . . . hospitalization. There are no Medicare benefits to be reimbursed or provided either now or in the future. Rather, plaintiff seeks damages for state law torts, which he alleges were inflicted by defendants as a result of their delay in granting the requested benefits. Moreover, contrary to defendants' assertion, the test for determining whether the claim arises under the Act is whether it is "inextricably intertwined" with a claim for benefits, not with the Act itself. Here, plaintiff is not seeking Medicare benefits, and thus his state law tort claims are not "inextricably intertwined" with a claim for Medicare benefits.

Kelly v. Advantage Health, Inc., 1999 WL 294796 at *12-13 (E.D. La. 1999).

This case virtually mirrors that in *Kelly*. Petitioner does not seek damages relating to the erroneous denial of Medicare claims, for he has already won that battle in the administrative review process. Thus, there are no Medicare reimbursement payments coming now or in the future. Instead of Medicare payments, petitioner seeks damages relating to the erroneous decision by respondent to place petitioner on the 100% prepayment review. And because petitioner does not seek benefits, his claim cannot be inextricably intertwined with the Medicare Act.

Respondent's assertion that petitioner's claim is distinguishable from the number of state law claims found not preempted, because those cases involved suits by patients rather than providers, is also misplaced. Resp. 18. First, nothing in the Medicare Act even remotely makes such a distinction. To the contrary, the Act applies the same administrative and judicial review process to "any individual." 43 U.S.C. § 405(g). In addition, if the distinction between patient and provider is the deciding factor between a claim inextricably intertwined with Medicare and one that is not, then patients could simply forego the administrative review process altogether, bringing erroneous benefits claims straight to court without preemption standing in the way. Nothing in *Heckler v. Ringer*, 466 U.S. 602 (1984), or the Medicare Act commands such a result.

Ultimately, respondent's argument – like that by the court below – cannot reasonably distinguish petitioner's case from the number of claims not requesting Medicare payments or benefits that have been allowed to go forward. *See e.g., Hofler v. Aetna US Healthcare of Cal., Inc.*, 296 F.3d 764 (9th Cir. 2002); *Ardary v. Aetna Health Plans of Southern California*, 98 F.3d 496 (9th Cir. 1996); *Kelly, supra*; *Livingston v. Blue Cross of Ala.*, 788 F.Supp. 545, 548 (S.D. Ala. 1992); *City of Worchester v. HCA Mgm't Co.*, 753 F.Supp. 31, 38 (D. Mass. 1990); *Group Health Inc. v. Blue Cross Assoc.*, 625 F.Supp. 69, 76 (S.D. N.Y. 1985); *Jamaica Hosp. Nursing Home v. Oxford Health Plans*, 2000 U.S. Dist. LEXIS 13917 (S.D.N.Y. 2000).

———◇———

CONCLUSION

This Court is presented with a question that has divided lower courts and impacts daily, the operation of this country's healthcare system. Also, the lower courts' treatment of petitioner's state law claims conflicts with both Congressional preference and this Court's decision in *Heckler*. For these reasons, review is warranted.

Respectfully submitted,

DR. DRALVES GENE EDWARDS
Pro Se
1532 Chapman Street
Cedar Hill, TX 75104
214-215-4425